CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

This form applies only to requests for confidential communications, i.e., when an individual is requesting a special manner of communication based on confidentiality concerns. This form is NOT to be used merely to notify Los Angeles County Department of Mental Health (LACDMH) of a change in address or other contact information.

Client Name: _____ Date: _____

Date of Birth: _____ IBHIS/IS #: _____

You have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see it, you may ask us to communicate with you by another method or at an alternative location, such as a post office box.

We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number).

Alternate Address (Postal):

_____

_____

_____

New Phone Number (Include Area Code):

_____

Indicate what method of communication NOT to use: _____

Signature of client or representative: _____

If representative, give relationship: _____

APPROVAL

Signature of Treatment Provider: _____ Date: _____

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